

MDR Tracking Number: M5-04-2757-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution - General and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. The dispute was received on April 27, 2004.

In accordance with Rule 133.307 (d), requests for medical dispute resolution are considered timely if they are filed with the division no later than one (1) year after the date(s) of service in dispute. The Commission received the medical dispute resolution request on 04-27-04, therefore the following date(s) of service are not timely and are not eligible for this review: 04-14-03 through 04-26-04.

The Medical Review Division has reviewed the IRO decision and determined that **the requestor prevailed** on the issues of medical necessity. Therefore, upon receipt of this Order and in accordance with §133.308(r)(9), the Commission hereby orders the respondent and non-prevailing party to **refund the requestor \$460.00** for the paid IRO fee. For the purposes of determining compliance with the order, the Commission will add 20 days to the date the order was deemed received as outlined on page one of this order.

In accordance with §413.031(e), it is a defense for the carrier if the carrier timely complies with the IRO decision.

Based on review of the disputed issues within the request, the Medical Review Division has determined that **medical necessity was the only issue** to be resolved. The office visits, therapeutic activities, myofascial release, joint mobilization, supplies and materials, therapeutic exercises, neuromuscular reeducation, gait training, neuromuscular stimulator, durable medical equipment and manual therapy technique from 4-30-03 through 7-10-03 were found to be medically necessary. The respondent raised no other reasons for denying reimbursement for the above listed services.

This Findings and Decision and Order is hereby issued this 10th day of August, 2004.

Donna Auby
Medical Dispute Resolution Officer
Medical Review Division

DA/da

On this basis, and pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay the unpaid medical fees in accordance with the fair and reasonable rate as set forth in Commission Rule 133.1(a)(8) plus all accrued interest due at the time of payment to the requestor within 20 days of receipt of this order. This Order is applicable to dates of service 4-30-03 through 7-10-03 in this dispute.

The respondent is prohibited from asserting additional denial reasons relative to this Decision upon issuing payment to the requestor in accordance with this Order (Rule 133.307(j)(2)).

This Order is hereby issued this 10th day of August, 2004.

David R. Martinez, Manager
Medical Dispute Resolution
Medical Review Division

DRM/Da

August 2, 2004

**NOTICE OF INDEPENDENT REVIEW DECISION
Amended Letter**

RE: MDR Tracking #: M5-04-2757-01
TWCC #:
Injured Employee:
Requestor:
Respondent:
----- Case #:

----- has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The ----- IRO Certificate Number is 5348. Texas Worker's Compensation Commission (TWCC) Rule §133.308 allows for a claimant or provider to request an independent review of a Carrier's adverse medical necessity determination. TWCC assigned the above-reference case to ----- for independent review in accordance with this Rule.

----- has performed an independent review of the proposed care to determine whether or not the adverse determination was appropriate. Relevant medical records, documentation provided by the parties referenced above and other documentation and written information submitted regarding this appeal was reviewed during the performance of this independent review.

This case was reviewed by a practicing chiropractor on the ----- external review panel who is familiar with the condition and treatment options at issue in this appeal. The reviewer has met the requirements for the ADL of TWCC or has been approved as an exception to the ADL requirement. The ----- chiropractor reviewer signed a statement certifying that no known conflicts of interest exist between this chiropractor and any of the treating physicians or providers or any of the physicians or providers who reviewed this case for a determination prior to the referral to ----- for independent review. In addition, the ----- chiropractor reviewer certified that the review was performed without bias for or against any party in this case.

Clinical History

This case concerns a 44 year-old male who sustained a work related injury on ----- . The patient reported that while at work he was involved in a motor vehicle accident, injuring his neck, left knee, and low back. The diagnoses for this patient have included status post left knee arthroscopy, partial medial meniscectomy and chondroplasty of trochlea and medial femoral condyle on 3/27/03, postoperative left knee pain and weakness, posterior ramus cervical radicular syndrome/complex-C5 radiculopathy to the left, clinically and electrodiagnostically (EMG 2/11/03), and mild lumbosacral radiculopathy to the left. The patient was initially treated

with conservative care. On 3/27/03 the patient underwent left knee surgery followed by postoperative therapy.

Requested Services

OV, therapeutic activities, myofascial release, joint mobilization, sup and materials, ther exercises, neuromuscular reeducation, gait training, neuromuscular stimulator, durable med equipment and man ther tech from 4/30/03 through 7/10/03.

Documents and/or information used by the reviewer to reach a decision:

Documents Submitted by Requestor:

1. Treatment summation 6/11/04
2. EMG report 2/11/03
3. Office notes 5/9/03 – 7/2/03
4. Operative note 3/27/03
5. Office/Progress notes 4/15/03 – 8/20/03
6. FCE 9/22/03

Documents Submitted by Respondent:

1. No documents submitted

Decision

The Carrier's determination that these services were not medically necessary for the treatment of this patient's condition is overturned.

Rationale/Basis for Decision

The ----- chiropractor reviewer noted that this case concerns a 44 year-old male who sustained a work related injury to his neck, left knee, and low back. The ----- chiropractor reviewer also noted that the diagnoses for this patient have included status post left knee arthroscopy, partial medial meniscectomy, and chondroplasty of trochlea and medial femoral condyle on 3/27/03, postoperative left knee pain and weakness, posterior ramus cervical radicular syndrome/complex-C5 radiculopathy to the left, clinically and electrodiagnostically, and mild lumbosacral radiculopathy to the left. The ----- chiropractor reviewer further noted that treatment for this patient's condition has included conservative care and left knee surgery followed by postoperative therapy. The ----- chiropractor reviewer explained that the patient responded well to the surgical procedure performed. The ----- chiropractor reviewer also explained that the patient also responded well to the postoperative therapy and recovered sufficiently. Therefore, the ----- chiropractor consultant concluded that the office visit, therapeutic activities, myofascial release, joint mobilization, sup and materials, ther exercises, neuromuscular reeducation, gait training, neuromuscular stimulator, durable med equipment and man ther tech from 4/30/03 through 7/10/03 were medically necessary to treat this patient's condition.

Sincerely,